MISKOVICH
DENTAL CLINIC P.C.

CHILD MEDICAL AND DENTAL QUESTIONNAIRE

Emergency Contact Number: _____

MEDICAL INFORMATION

If "YES" to any of the following items or if you are unsure, please explain below

	YES	NO
GROWTH AND DEVELOPMENT		
1. Were there any complications during pregnancy or was child premature at birth?	☐	☐
2. Has the child had psychological counseling or is counseling being considered for the near future?	☐	☐
3. Any learning, behavioral, excessive nervousness, or communication problems?	☐	☐
4. Any problems with physical growth?	☐	☐
CENTRAL NERVOUS SYSTEM		
5. Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	☐	☐
6. Any history of injury to the head?	☐	☐
7. Any sensory disorders? (seeing, hearing)	☐	☐
CARDIOVASCULAR SYSTEM		
8. Any history of congenital heart disease, heart murmur or other heart damage (e.g. rheumatic fever)?	☐	☐
9. Has any heart surgery been done or recommended?	☐	☐
10. Any history of chest pains or high blood pressure?	☐	☐
HEMATOPOIETIC AND LYMPHATIC SYSTEMS		
11. Has your child ever had a blood transfusion or blood products transfusion?	☐	☐
12. Any history of anemia or sickle cell disease?	☐	☐
13. Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts?	☐	☐
14. Is your child more susceptible to infections than other children are?	☐	☐
15. Is there any history of tender or swollen lymph nodes or glands?	☐	☐
RESPIRATORY SYSTEM		
16. Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing?	☐	☐

	YES	NO
GASTROINTESTINAL SYSTEM		
17. Any history of stomach, intestinal, or liver problems?	☐	☐
18. Any history of hepatitis or jaundice?	☐	☐
19. Any history of eating disorders, such as anorexia nervosa (binge/purge) or bulimia (binge)?	☐	☐
20. Any history of unusual weight loss/gain?	☐	☐
GENITOURINARY SYSTEM	☐	☐
21. Any history of urinary tract infections, bladder, or kidney problems?	☐	☐
22. Is the patient pregnant or possibly pregnant?	☐	☐
ENDOCRINE SYSTEM		
23. Any history of diabetes?	☐	☐
24. Any history of thyroid disorders or other glandular disorders?	☐	☐
SKIN		
25. Any history of skin problems?	☐	☐
26. Any history of cold sores (herpes) or canker sores (aphthae)?	☐	☐
EXTREMITIES		
27. Any limitations of use of arms or legs?	☐	☐
28. Any arthritis or other joint problems?	☐	☐
29. Any problems with muscle weakness or muscular dystrophy?	☐	☐
ALLERGIES		
30. Is your child allergic to any medications?	☐	☐
31. Any hay fever, hives, or skin rashes caused by allergies?	☐	☐
32. Any other allergies?	☐	☐

Explanation:

NAME, ADDRESS & PHONE NUMBER of your child's medical doctor _____

_____

MEDICATIONS OR TREATMENTS Is your child currently taking any medication (prescription or non-prescription medicine)? YES ☐ NO ☐

If yes, Medication(s): Dosage Times Per Day

_____ _____ _____

_____ _____ _____

HOSPITALIZATIONS Has your child ever been hospitalized? YES ☐ NO ☐

_____ _____ _____

(Hospital) (Date) (Reason)

IMMUNIZATIONS Is your child presently protected by immunization against DPT [diptheria, whooping cough (pertussis), Tetanus], polio, measles, mumps, and German measles (rubella)? YES ☐ NO ☐

Please check any of the following that your child has now, has recently been exposed to, or has had in the past

	YES	NO		YES	NO
Immune deficiency diseases including HIV/AIDS	☐	☐	Mumps (parotitis)	☐	☐
Chicken pox (varicella)	☐	☐	Scarlet fever (scarlatina)	☐	☐
Earache (otitis)	☐	☐	Sore throat (tonsillitis or pharyngitis)	☐	☐
Eye infection (conjunctivitis)	☐	☐	Substance abuse, alcoholism, drug addiction	☐	☐
German measles or 3-day measles (rubella)	☐	☐	Upper respiratory infection (URI), or common cold	☐	☐
Glandular fever or mono (infectious mononucleosis)	☐	☐	(pharyngitis, rhinitis, sinusitis, or tonsillitis)	☐	☐
Measles (rubeola)	☐	☐	Sexually transmitted diseases	☐	☐

ORAL HEALTH HISTORY

	YES	NO
Does your child have a toothache or other immediate dental problem?	☐	☐
Has your child ever had a toothache?	☐	☐
Has your child had any injury to the mouth, teeth, or jaws (fall, blow, etc.)?	☐	☐
Date of last dental visit _____		
Date of last dental x-rays _____		
Is this the first dental visit for your child?	☐	☐
Has your child ever had an unfavorable dental experience?	☐	☐
Is (was) your child nourished by nursing beyond one year of age? If yes, check: Breast _____ Nursing bottle _____ To what age?_____	☐	☐
Does your child eat a well-balanced diet? If no, what foods or food groups are not adequate? _____	☐	☐
Does (or has) your child have (or had) sucking habit beyond one year of age? If yes, check: Thumb(s) _____ Finger(s) _____ Pacifier _____ Other _____	☐	☐
Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks?	☐	☐

	YES	NO
Does (or has) your child have (or had) any other oral habits beyond one year of age? If yes, check: Lip Biting _____ Mouth Breathing _____ Nail Biting _____ Teeth Grinding _____ Other _____	☐	☐
Please explain if you answered "YES" to, or are uncertain about, any of the above items: _____		
How often is tooth brushing performed? _____ time(s) per _____		
Does your child use dental floss?	☐	☐
Does someone assist your child with brushing and cleaning the teeth?	☐	☐
Does someone inspect for thoroughness after the procedure?	☐	☐
Does your child use a fluoride toothpaste?	☐	☐
Has your child ever had a fluoride treatment?	☐	☐
Has your child ever taken a fluoride supplement or vitamins with fluorides?	☐	☐
Does your child drink tap water?	☐	☐
Does your child drink bottled water?	☐	☐

MEDICAL/DENTAL HEALTH UPDATE - Please verify changes in your health status at regular intervals.

Date	Change in Health Status	Signature
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____

Date	Change in Health Status	Signature
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____

Father's Name _____ Age _____ Marital Status:

Mother's Name _____ Age _____ S M W D Sep

Brothers (names and ages) _____

Sisters (names and ages) _____

Pets _____ Hobbies _____

Reason for visit: _____

To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature - Patient (or parent/guardian if patient is under age 18) Date